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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SARANDAR KOUR NEWELL,** **a.k.a. SARANDAR KOUR SINGH** **13373 Orange Road** **Wilton, California 95693** **Registered Nurse License No. 563651** Respondent.	Case No. 2011- 815 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (hereinafter "Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (hereinafter "Board"), Department of Consumer Affairs.

2. On or about February 10, 2000, the Board issued Registered Nurse License Number 563651 (hereinafter "License") to Sarandar Kour Newell, also known as Sarandar Kour Singh (hereinafter "Respondent"). Respondent's License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2011, unless renewed.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code (hereinafter "Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. California Code of Regulations, title 16, section (hereinafter "Regulation") 1442 states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

7. Regulation 1443 states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. Regulation 1443.5 states, in pertinent part:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

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(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

. . . .

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that while employed as a registered nurse in the Treatment and Triage Area (hereinafter "TTA") at Mule Creek State Prison, a facility of the California Department of Corrections and Rehabilitation (hereinafter "CDCR") located in Ione, California, Respondent was guilty of gross negligence in her care of inmate-patients within the meaning of Regulation 1442, as set forth in paragraphs 11 through 13 below.

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Patient 1[1]:

11. On or about June 9, 2007, Patient 1 was sent to the TTA with a complaint of a foreign object in his left eye. Licensed vocational nurse (hereinafter "LVN") D. arrived in the TTA and overheard Respondent tell Patient 1 that there was nothing she could do for him. LVN D. asked Respondent whether she observed a foreign object in Patient 1's eye. Respondent told LVN D. that she could not see anything in Patient 1's eye without an eye examination machine. LVN D. suggested that Respondent flush Patient 1's eye with solution. Respondent told LVN D. that there was only one bottle of eye solution left in the TTA and that she did not want to run out. Later, LVN D. observed ten bottles of eye solution in the stock room. Respondent was guilty of the following acts or omissions in her care of Patient 1:

a. Respondent failed to use an eye examination machine to check Patient 1's eye for a foreign object;

b. Respondent failed to flush Patient 1's eye with solution; and,

c. Respondent failed to refer Patient 1 to a physician.

Patient 2[2]:

12. On or about August 8, 2007, Patient 2 came to the TTA with complaints of left-sided chest pain. Subsequently Respondent arrived at the TTA to take over for registered nurse K. M who had initiated treatment of Patient 2. Respondent was guilty of the following act or omission in her care of Patient 2:

a. Respondent pulled an EKG machine away from Patient 2 without unhooking the leads from the Patient 2, causing the leads to be ripped off Patient 2 while he lay on a gurney.

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[1] Patient 1 as identified in this Accusation is the same patient identified as Patient B in the investigation by the Department of Consumer Affairs, Division of Investigation (hereinafter "DOI") and as Patient A in CDCR's adverse action dated March 24, 2009, (hereinafter "Adverse Action") and the report of Josephine Ridad dated June 7, 2010 (hereinafter Ridad Report).

[2] Patient 2 as identified in this Accusation is the same patient identified as Patient C in the investigation by DOI and Patient E in the Adverse Action and the Ridad Report.

Patient 3[3]:

13. On or about August 7, 2007, Patient 3 was brought to the TTA for multiple self-inflicted wounds (cuts and scratches) as he had become suicidal. Respondent began cleaning the Patient 3's wounds with a towel, but stopped and told Patient 3 that since he had cut himself, he would have to clean himself. Patient 3 was then placed in a holding cell. After approximately four hours, Patient 3 was sent back to his cell without being treated. Patient 3's wounds continued to bleed until an another nurse in Patient 3's housing unit observed his condition, and cleaned, treated, and dressed the wounds. Respondent was guilty of the following acts or omissions in her care of Patient 3:

a. Respondent failed to cleanse, treat, and dress Patient 3's wounds.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

14. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that while employed as a registered nurse in the TTA at Mule Creek State Prison, Respondent was guilty of incompetence in her care of patients within the meaning of Regulation 1443, as set forth in paragraphs 11 through 13 above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that while employed as a registered nurse in the TTA at Mule Creek State Prison, Respondent committed acts constituting unprofessional conduct in her care of patients as set forth in paragraphs 11 through 13 above.

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[3] Patient 3 as identified in this Accusation is the same patient identified as Patient A in the investigation by DOI and Patient F in the Adverse Action and the Ridad Report.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 563651, issued to Sarandar Kour Newell, also known as Sarandar Kour Singh;

2. Ordering Sarandar Kour Newell, also known as Sarandar Kour Singh, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/29/11

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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